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Children's Integrated Services prenatal to 22 years old: Redesign Description DRAFT combined with Challenge Summary Document

Charge

AHS will design and implement a family and child centered system of early intervention, treatment and support. Though reduced to adhere to the *Challenges* constraint, funding will be flexible and based on best practices and family needs. The system will strive to intervene early in a preventive fashion, and provide services to the family unit, not just the child. Each child and family in the early intervention, treatment and support system will have measurable goals against which progress will be assessed.

- The early intervention, treatment and support system will:
 - retain content experts in early childhood, mental health, developmental disability, substance use, etc.,
 - operate with standards for best practice and,
 - develop unified AHS guidelines for effective treatment and family support.
- The early intervention, treatment and support system will be readily available to meet the child protection and guardianship responsibilities of the state.
- The early intervention, treatment and support system must be linked to and support those health and human services which are preventative in nature and which address the whole population and offer developmental, health and behavioral health benefits.
- The early intervention, treatment and support system will actively collaborate with DOE on efforts to unify services for families in a comprehensive manner.

Goal

Integrate human service efforts to create a continuum of services for families to choose from and base service on diagnostic and functional needs of the child, youth and family.

Services will be guided by best practices in clinical service, early intervention and family support. The system will monitor outcomes and integrate AHS funding across programs in order to meet these goals effectively.

Background and Current Focus

Currently AHS children's services fall in five Departments and multiple divisions of the agency. Division and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for managing sub-specialty populations within various departments. While the best approaches available at the time, the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines about our work with children and families. With the inception of the Global Commitment waiver, these siloed Medicaid funding structures no longer exist.

The Integrated Family Services Initiative seeks to bring all agency children, youth and family services together in an integrated and consistent continuum of services for families. **The premise being that giving families early support, education and interventions will produce more favorable outcomes at a lower cost than the current practice of waiting until circumstances are bad enough to access high end funding streams which often result in out of home or out of state placement.**

Efforts across the agency over the past several years have moved in the direction that this initiative champions. For example, DCF- Family Service Division has instituted a Differential Response system which seeks to apply resources and intervention earlier to focus on mitigating risk and thus increase child safety and family unity. VDH- Children with Special health Needs, DCF- Child Development Division and OVHA have been fully integrating administrative and operational procedures for service authorization, billing and tracking for the last 10 months.

The basic elements of this model will also be integrated with the Blueprint Community Health Teams and the expanded OVHA Chronic Care initiative. The integrated family services effort will support and over time expand on wellness coaching and ensure a connection with the developing health information

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exchange network and modernized information technology efforts to maximize their applicability to the child and family services efforts. Additionally, proposals by OVHA and DMH to assure that the best clinical practices are utilized in the Medicaid program will be integral to this initiative relative to clinical practices in mental health, behavioral health, medical and medication management for children, youth and families.

System of Measurement (Annually)

Note: Over time and with full modernization of the AHS Information technology Infrastructure (see separate detail write-up), more precise longitudinal and other intervention specific measures will be available for implementation in outcome tracking. This capability is currently inhibited by disparate and outdated technology systems and the historical isolation of programs that resulted in separate program and data collection efforts.

Outcome	Indicators
Pregnant Women and Young Children Thrive	<p>Developmental Progress measures used in 0-6 early childhood programs</p> <ul style="list-style-type: none">• Increase the percent of children 0-6 years old who achieve 1 or more of their goals as defined annually in their Integrated Services Family Plan <p>Increase the percent of children enrolled in child care programs who regularly attend a quality child development program.</p> <p>National HEDIS¹ Measure used in Global Commitment to Health</p> <ul style="list-style-type: none">• Increase the percent of women receiving prenatal and post care in the Global Commitment to Health Population• Increase the percent of well child visits in the first 15 months of life-in the Global Commitment to Health Population• Increase the percent of well child visits in the third - sixth year of life in the Global Commitment to Health Population <p>School Readiness Survey Data</p> <ul style="list-style-type: none">• Increase the percent of children who are ready for Kindergarten <p>To be developed</p> <ul style="list-style-type: none">• Increase the rate of developmental screening in early childhood according to national guidelines
Children live in Stable and Supported Families	<ul style="list-style-type: none">• Decrease the rate of child abuse and neglect

¹ HEDIS (Healthcare Effectiveness Data and Information Set) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across 8 domains of care. Because so many health plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts. *HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

Outcome	Indicators
	<p>substantiations</p> <ul style="list-style-type: none"> • Decrease the percent of children and youth in out of home placement • Increase positive family reports of experience of care (did you get what you need, were you treated with respect, did it help, etc) • The percent of families who have one integrated family plan • The percent of goals of integrated family plans which are met • Increase the percent of family and youth competencies outside of the clinical range as measured by the Achenbach System of Emotional Behavioral Assessment. (ASEBA) for children, youth and families.
Youth Choose Health Behaviors	<ul style="list-style-type: none"> • Decrease in the percent of youth reporting substance abuse, smoking and unhealthy behaviors as self reported by youth using the Youth Risk Behavior Survey • Implement an assets based data collection tool for youth system wide and report on the percent of youth reporting indicators of positive youth development

Assumptions:

- AHS will fund services that promote and strengthen the family system as a whole, not isolated programs
- AHS services overall will exist on a continuum which moves from prevention to early intervention to treatment
- A consistent and common assessment process will happen across disciplines and will determine the functional need for services of the child, youth and family.
- Assessment will result in a single, holistic family plan that represents all AHS funded treatment and support services, and it will be complimentary to the IEP when an IEP is necessary.
- Regardless of where a child or family enters to access AHS funded treatment and support services, it will lead to a consistent and common assessment process, method for service planning and allocation of services.
- Services will be delivered in an intentional and developmentally appropriate order based on the needs and desires of the family with a logical progression defined by the family plan.
- Eligibility will be simplified and must be common across disciplines. Criteria will be developed which defines what level of functional impact warrants funding and intervention.
- Documentation will be simple and must be common across disciplines.
- Funding will be flexible and must allow for needs-based interventions, support and treatment and
- Service types and provider performance will be tracked and linked to outcomes.

Early and Periodic Screening, Functional Assessment and Diagnosis:

Ideally and over time, families will enter the system through the recently established early childhood screening (prenatal to 6) processes. Each child and family will have a medical home and if needed a Children's Integrated Services (CIS) Team.

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Any family that enters the system later than age six will be referred to a local team and a multi-disciplinary screening ensured. Every family with a child determined to have a disability or developmental delay will be assessed according to:

- a. standard assessments for the identified or suspected problem; and,
- b. common, consistent and comprehensive functional assessment process.

The overall goal would be to have a local structure like the prenatal to six efforts that supports a multi-disciplinary and common screening, triage, assessment, consultation and unified/integrated service delivery plan.

Early Intervention and Treatment

Eligibility for intervention and treatment services will be based on current functional impact, regardless of diagnosis.

Criteria will be developed which defines what level of functional impact warrants funding and intervention.

Each child and family, in addition to a medical home, will have a lead care coordinator/case manager who is responsible for assuring the needed services are arranged and delivered and who will work closely with the a local team and other service agencies as needed.

Services will be arranged to meet the family and child needs, within budgetary constraints. The family, with a lead coordinator, will have a primary role in determining the services the family needs to best care for the child. The medical home and service providers will utilize best practices.

Available services will include at a minimum:

- a. Early and periodic screening and diagnosis
- b. Primary care
- c. Acute care as required
- d. Medication as required
- e. Therapies including physical, occupational, speech and language
- f. Personal care
- g. Mental health care
- h. Behavioral interventions
- i. Respite
- j. Family Support, Skill building and Education
- k. Transportation
- l. Durable medical equipment
- m. Medical supplies
- n. Residential/Out of Home options when necessary, time limited and as a last resort
- o. Consultation to early childhood, afterschool and other caregiver settings
- p. Care coordination/case management

The lead care coordinator will work with the family to develop a proposed plan of care based on the assessments obtained and best practices and to agree on a plan with measurable goals for the family.

Each family and child plan will have a funding plan or designated level of care which guides allocations of the AHS funds. Exploration must occur with providers and Medicaid consultants to determine reimbursement models and cost methodologies. One possible outcome may be that plans are based on a bundled rate methodology to one provider agency that will ensure services are arranged and delivered.

Some services that support children and families will continue to be outside the bundle (such as acute care and WIC food benefits). However, the provider agency and lead care coordinator/case manager will

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continue to be accountable for the provision of all services, even if a child is hospitalized or enters a residential setting.

Possible options for Rate Bundles

All children	Bundled Services	Fee for Service
Screening and diagnosis	Personal Care	Hospital care
Immunization	CHSN	Medications
WIC- food benefit	High Tech	Primary Care
Population Based	Therapies	Psychiatry
Prevention	Case management	Psychology
	Respite	Durable Medical equipment
	Behavioral intervention	
	Family Support, skill building and education	
	Residential & other out of home placement	
	Medical supplies	
	Consultation, Education and Outreach to care giving settings	

School Age Children

The lead care coordinator will be the AHS system's representative at IEP meetings and will ensure that the AHS family plan and IEP are fully coordinated.

Financing

All funding across AHS divisions targeted as fitting the "treatment and support" category of services, will be identified and managed as a global children's budget and by an AHS team. Services identified as falling into this category include:

- AHS High Risk Pool
- Children with Special Health Needs
- ADAP Adolescent Treatment services; Student Assistance Programs; Services to pregnant women
- DCF – Family Services Division, Intensive Family Based Services; Parent Education; Child and Family Supports (in part); Sex offender Treatment Services; Victim Treatment services; Individualize Service Budgets/waivers; private non-medical institutions; runaway and homeless youth programs; post adoption support services.
- DCF- Child Development Division; Specialized Child Care; prenatal to six children's integrated services programs
- DCF – Lund Family Center
- DAIL – VR- JOBS; DS-Bridges; Flex Family Funds (in part 0-22); Home and Community Based Services (in part 0 – 220; TBI (in part 16-22) DS Clinic Svs (in part 0-22); Children's Personal Care Services; Hi Tech (in part 0-22)
- DMH- All child and family programs

Information Technology (IT)

Assessments and screenings, services received, progress notes and outcomes will be entered into an electronic client record. HIT/HIE capability will be available to all service providers and the family. IT will include necessary federal reporting capability and connect with Medical Home records.

Data on actual spending per child and per local region and/or team will be recorded, shared and analyzed monthly.

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Data on outcomes will be recorded, shared and analyzed per local region and statewide.

Areas under development in AHS that will support Integrated Family Services include:

Enterprise Master Person Index - unduplicated information and ability to track for consumers prenatal to 22 years old.

Medicaid Management Information System – service authorizations, ability to make payments from all fund sources combined (not just Medicaid), utilization and costs reports

Work Flow tools – to assist with case tracking/management tools - within AHS and between AHS and its grantees and contractors

Health Information Exchange networks within AHS and between AHS and its grantees and contractors

Data warehouse and central source for the measurement and integration of data from disparate AHS and provide sources.

Opportunities for savings across all AHS programs

1. Practice changes

- a. Earlier intervention strategies
 - Strengthen and unify prenatal and early childhood services and family support to mitigate risk factors and challenges that are already present.
 - Implement practice changes to promote strong family systems, shared decision making, goal directed family plans and strength based interventions to decrease:
 - use of more intensive and costly services
 - long term negative effects of living within stressful and challenging environments for all family members
 - Make available low cost services (respite, personal care, increase family capacity skills and supports) that can alleviate the need for more expensive and intensive services.
 - Provide families with support and skill building as needed to move towards decreasing reliance on public sector and/or more costly services.
- b. Common screening, intake, and assessment process
 - Ensure the right services are delivered at the right time for the right purpose.
- c. Single point for care coordination
 - Reduce duplication of services, labs, assessments, etc.
 - Ensure targeted plans to address immediate needs.
 - Monitor effectiveness and adjust services as needed in a timely fashion
- d. Strengthen integrated medical home model
 - Stronger communication and integration of interventions to accomplish all of the above.

2. Administrative changes to reduce and simplify overhead

- Single documentation system
- Bundled reimbursement strategies (i.e., capitation payments, case rates, level of care rates, etc.) versus separate and disparate approaches across divisions
- Simplified and common billing mechanisms

3. Infrastructure Changes

- Health Information Exchange and data exchange systems that eliminate duplicate data entry and info capture
 - Reduce duplication of data entry and repeat service referrals
 - Reduce administrative overhead
 - Prompt timely review of service type and utilization

4. Other Benefits

- Improved effectiveness—focusing resources on evidence-based practices shown to produce results
- Focus on results rather than purchasing units of service
- Less meeting time, less time for families repeating the same story and needs over and over

Stakeholder Involvement and Communication Plan

2008-2009 The Integrated Family Service Concepts grew out a process that began with an intensive focus on children and families prenatal to six years old. Stakeholders in these 0-6 year old discussion included legal aid staff, parents and staff from Vermont Children's health Improvement Program at UVM.

July 2009 Families were invited to join AHS staff to begin discussions of the larger continuum of services from prenatal to 22 years of age. The Vermont Federation of Families for Children's Mental Health sent a designee to what was then a cross departmental work group of AHS staff. Vermont Family Network did not respond to the invitation.

September 2009 – A large Stakeholder group (Educators, DA reps, primary care and family practice doctors, early childhood and other provider networks) were asked to attend a workshop on integrated services and promotion of health and well being for children. This workshop was provided free of cost to Vermont by the Maternal and Child Health Division of Federal Department of Health and Human Services.

February 2010 Vermont Family Network joined the AHS discussion by designating a parent representative to group.

March 19, 2010 – A large Stakeholder group was convened for the purpose of getting feedback and guidance on the overall vision, the process and the basic elements of the redesign as well as to indicate interest and willingness to participate in workgroups targeting basic elements of the system redesign. Over 50 participants from all aspects of child, youth and family system (public and private) attended.

Next Steps

1. Identify and convene ad hoc work groups on various aspects of the redesign basic elements including participation of providers and other stakeholders.
2. Form a 5-7 person parent advisory panel to review guidelines and other products that emerge from the redesign work – youth voice will be added using the current youth in transition grant connection.
3. Individual departments use their existing advisory bodies as needed for input.

Summary of Basic Elements Integrated Family Services

Policy

<i>From Current</i>	<i>To Redesign</i>
Family centered, child focused	Family systems, strength based & shared decision making with families
Eligible only when <i>bad enough</i>	Early intervention, treatment and support
Diagnosis driven	Diagnostic and functionally driven

Program

<i>From Current</i>	<i>To Redesign</i>
Separate screenings, intakes and assessments	Common & consistent family screening, intake and multi-disciplinary assessment process
Separate guidelines and criteria	Unified and common AHS guidelines and criteria
Separate programs, separate plans	Integrated services and single plan,
Separate documentation	One common documentation set
Multiple case management/service coordination definitions and providers	One definition and single lead coordinator
Child diagnosis	Family & child functioning
Medical home separate from social/behavioral	Integrated medical home & teaming

Fiscal, Contract, IT

<i>From Current</i>	<i>To Redesign</i>
Units of service	Bundled rate and outcome measures
Multiple contracts and grants– similar services	Unified and simplified administrative and program oversight activity
Individually negotiated rates/budgets for each provider by each AHS division	Statewide rate/outcomes drive budget
Fragmented or outdated IT	HIE/HIT advances & modern IT structures

Structural – Central Office

<i>From Current</i>	<i>To Redesign</i>
Individual departments/division	Integrated family services team and global budget for early intervention, treatment and support

Structural –Regions

<i>From Current</i>	<i>To Redesign</i>
Multiple individual providers with separate systems and standards, intakes, budgets based on separate expectations from each AHS division	Unified local network/continuum for direct services Multi-disciplinary team approach available with consistent guidelines in each region: <ul style="list-style-type: none"> - triage, intake, referral, plan - expert consultation/assessment team